EX POST PAPER

Understanding the mental health disorders pathway leading to violent extremism

Summary

The relation between mental health disorders and acts of violent extremism has received increased attention in recent years. Several practitioners note that radicalised individuals have **specific neuropsychiatric disorders** like **autism spectrum disorder** or **schizophrenia**. The specific symptoms of these disorders could cause mild concern for practitioners from different fields. This paper **identifies risk factors** that make these people **vulnerable to violent extremism**, as well as ways that **professionals** can **assess protective factors** which may contribute to **safeguarding** them. Without oversimplifying and stigmatising people with a mental health disorder, there is a **need for a better understanding of the implications of these vulnerabilities**, and possibly even perceptibility to radical ideas, to improve prevention efforts. Lastly, **recommendations at a practical and policy level** are formulated.

*This paper is a product of the RAN Centre of Excellence and the RAN H&SC Working Group. Authored by **Jordy Krasenberg** and **Lieke Wouterse**, RAN Centre of Excellence.*

Mental health disorders as a pathway to extremism

The question of the possible presence of mental health disorders among lone actor terrorists is a much debated one. In the RAN H&SC (2016) working group meeting on identifying and treating lone actors([1]), there was a general consensus among participants that it is **very difficult to identify a person at risk of radicalising** or committing an act of violent terrorism **on the basis of mental health disorders alone**.

At the follow-up RAN H&SC (2017) meeting on the **Risk assessment of lone actors**([2]), it was noted that there is a **growing trend for individuals** or small cells to **act in isolation** from a wider group to conduct terrorist activity and that, among these individuals, **mental health disorders are more prevalent** than among group actors.

Numerous practitioners noted that their clients (radicalised or potentially violent) suffered from specific disorders like **autism spectrum disorder (ASD)**, delusional ideas and **schizophrenia**. ASD is different from many other mental disorders, because it's considered a **neurological development disorder**. This leaves the question of how ASD and other similar disorders could **be a context of engagement in violent extremism**. What **aspects** of mental health disorders could directly drive the **pathway** to extremism? Which aspects of mental health disorders could function as **protective factors** against radicalisation?

Practitioner experiences and the literature

State-of-play: Three literature phases on terrorism and mental health disorders	
1st Phase:	Terrorists are mentally ill (inference – terrorism directly caused by mental illness);
2nd Phase:	Terrorists are all mentally healthy (inference – all rational, calculated);
3rd Phase:	Terrorists are a diverse population – some have mental health disorders (data has many limitations);

In recent years, practitioners working in the field of P/CVE have pointed to a **potential link** between **mental health disorders** on one side, and **radicalisation** on the other. However, academic research on the prevalence of mental health disorders among terrorists has failed to produce clear evidence supporting this hypothesis. In fact, studies conducted since 2012 seem to repeatedly reach the conclusion that there is **no clear connection** between mental health disorders and terrorism. This conclusion corresponds with the third phase of the literature on terrorism and mental health disorders ([3]). According to practitioner experiences, we need to be cautious about the literature we rely upon.

In autism and mental health work, there are publications by passionate and excellent academics, but they don't always **have experience of clinical trials (CT)** with patients and, in some cases, autistic patients. This can lead to a **gap between academic literature and real life practice and experiences**. Some of the evidence that practitioners have gathered is not publishable, which could be explained by difficulties encountered with sharing and publishing **confidential data**, due to

[1] RAN H&SC, Working group meeting on identifying and treating lone actors, Ex post paper. Zagreb, Croatia, 27–28 January 2016.
[2] RAN H&SC, Risk assessment of lone actors, Ex post paper. Mechelen, Belgium, 11–12 December 2017.
([3]) Presented during the H&SC meeting on 'Understanding the mental health pathway to violent extremism', Turin, Italy, 13 March 2019.

medical confidentiality agreements, **legislation (GDPR)** or **governmental disclosure limitations** ([4]). The limitations of current research include: sample size, the nature of the link, under-diagnosis and a lack of access to data. It is also significant to highlight that most studies to date of individuals with ASD involved with the criminal justice system have focused on **men** and very little is known of the **socio-economic status** or ethnicity of **offenders with ASD** ([5]).

Mental health disorder or radicalisation?

There seems to be agreement amongst practitioners that the **mental health disorder aspect is more important than the radicalisation aspect in preventing violent extremism**. It was considered important for all practitioners to know that they are not always linked and that these can be two separate variables. Practitioners sometimes have the tendency to focus on radicalisation too much, but at the same time they cannot dismiss it completely in their assessment. Practitioners and researchers need to **examine mental health disorders in a nuanced** and specific way and **identify functional links between specific aspects of the mental health disorder and specific ways that this contributed to their patients' pathways to extremism.** A mental health disorder may contribute **directly or indirectly** to the pathway leading to extremism. Some participants found that there is enough research evidence for a number of psychological, psycho-social, cognitive and social factors that may contribute to the **pathway** and that a **mental health disorder is considered one of them**.

Direct Pathways

- ***Symptoms command violence***.
- ***Threat Control Override symptoms (TCO).*** *Mental health disorder overrides self-control and behavioural constraints by intensifying experienced threat and fear of harm.*

One thing is certain. **We can't dismiss mental health disorders as a risk factor** leading people on the path to violence or violent extremism. According to some researchers and practitioners, we can observe a greater prevalence of mental health disorders amongst terrorists due to **on-line entry**, mass recruitment tactics and higher exposure to threats, grievances and propaganda. There is a sense of urgency to do more to **prevent vulnerable individuals with mental health disorders from joining terrorist groups** or committing terrorist acts in the name of a terrorist organisation. This requires well-informed policy and needs to be done with care to prevent self-fulfilling prophesies through stigmatisation, uninformed assessments or people who are already vulnerable to be unnecessarily harmed. Practitioners always need to keep in mind that **when you change the label, you**

Indirect Pathways

- ***Social or interpersonal processes*** *intervene between mental health disorders-crime (e.g. others challenging symptoms, controlling patient, bullying).*
- ***Social structures/factors*** *determine violent expression of symptoms (e.g. social modelling of aggression, drugs, threat in violent or low socioeconomic environments).*

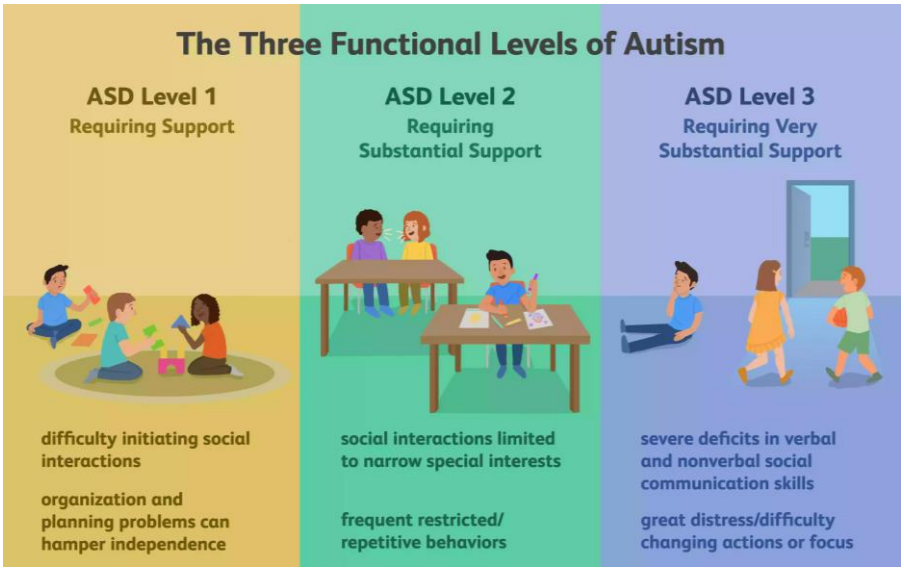
([4]) Schulten, N., Doosje, B., Spaaij, R., & Kamphuis, J. H., Radicalization, terrorism & psychopathology: State of affairs, gaps and priorities for future research. WODC, 14 January 2019.

[5] Murphy, D., & Allely, C., Autism spectrum disorders in high secure psychiatric care: A review of literature, future research and clinical directions. Advances in Autism, 2019. doi:10.1108/AIA-10-2018-0044

change someone's destiny. Since prevention is aimed at disrupting the early stages of the pathway leading to violent extremism, an adequate and informed **intervention** can result in insights and skills that may encourage an individual to leave the pathway and manage its triggers. People follow a journey before they commit an act of terrorism and, somewhere on that journey, people with a mental health disorder can be **safeguarded**. This paper will now look at the **specific case of ASD** to gain a **better understanding** of why mental health disorders should have a prominent place in prevention, **what can be done** and **how this is best achieved,** according to practitioners.

Autism Spectrum Disorder and Asperger's syndrome

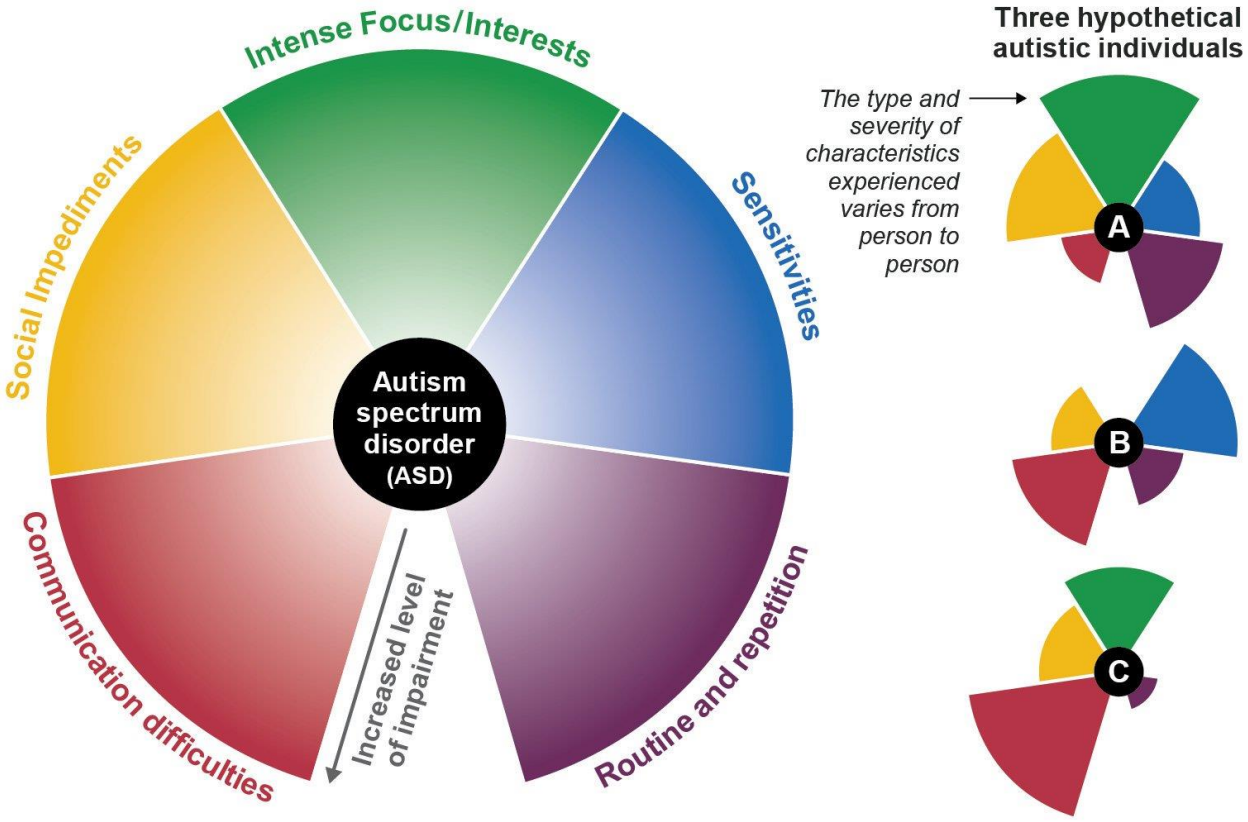
On average, about 1% to 2% of children and almost as many adults have autism or Asperger's syndrome, or another autism spectrum disorder ([6]). **Autism** is a disorder/variation of brain function with symptoms that appear early in life, generally before the age of three. Children with autism have problems with social instinct and interaction, communication, imagination and behaviour. Autistic traits persist into adulthood, but vary in severity. Autistic traits without additional impairment are probably quite common in the general population. Autism manifests itself in difficulties in relating to and communicating with others, resulting in social isolation. People with autism can often be perceived as if they live in a world of their own ([7]). **Asperger's syndrome** is a condition similar to autism but without a clinically significant language delay following the toddler years. Language, however, is still used in a stilted and stereotyped manner. People with Asperger's syndrome usually have no general cognitive delay, meaning their overall IQ is usually in the normal range or above. Some authorities make a distinction between Asperger's syndrome and **High Functioning Autism (HFA)**, but most do not. Many experts argue that autism and Asperger's syndrome are the same disorder, only separated by language difficulty and lower IQ in the former diagnostic group. In the new version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) ([8]), the two have been merged into one category - autism spectrum disorders. Keep in mind that Autism Spectrum Disorder is, in fact, a spectrum with different traits being more dominant ([9]).



([6]) See: https://www.cdc.gov/ncbddd/autism/data.html
([7]) See: https://www.nimh.nih.gov/health/publications/autism-spectrum-disorder/autismspectrumdisorder-508_152236.pdf
([8]) See: https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/frequently-asked-questions
([9]) See: https://www.verywellhealth.com/what-are-the-three-levels-of-autism-260233

Figure 2: Variation in Autism Spectrum Disorder Characteristics

GAO grouped the characteristics associated with autism into five broad categories, with some overlap between categories.



Source: GAO analysis of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). | GAO-17-109

Risk Factors, needs and vulnerabilities

Most individuals with an ASD who offend do so because of a combination of reasons. Typically, these reasons are linked to personal circumstances, such as dealing with periods of **transition or change**, and the difficulties associated with having an ASD. These include **social naivety**, **pursuing a preoccupation** or **failing to appreciate the consequences of one's actions**, **theory of mind difficulties**, **emotional regulation difficulties**, as well as **co-morbidity** ([10]) with another **psychiatric disorder** ([11]). Where a radicalised individual has a **diagnosis of autism**, it is necessary to assess the extent to which the different aspects of autistic functioning determine his or her offence trajectory and modus operandi. In this context, several facets of autism are particularly relevant.

([10]) More on this can be found via https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-papers/docs/exit_hsc_paper_joint_meeting_vienna_07112018_en.pdf

[11] See for example Newman, S. S., & Ghaziuddin, M., Violent crime in Asperger syndrome: The role of psychiatric comorbidity. Journal of Autism and Developmental Disorders, Vol. 38, Iss. 10, 2008, 1848–1852.

Facet of autism	Relation with (pathway to) violent extremism
Circumscribed or restricted interests	Persons with autism generally develop a high interest in specific topics (e.g. history, politics, technical interests), which they pursue tirelessly. When doing so, they may stumble upon extremist propaganda. Furthermore, a circumscribed interest in, for instance, explosives or Nazi symbolism may lead to radicalisation. Dark interests tend to be more common e.g. arson and sadistic porn. Technical skills coupled with social impairments can make an individual with ASD a target for exploitation ([12]).
Visual Fantasy & Impaired Social Imagination	In conjunction with limited social imagination: this can lead to acting out an image or a story that they have seen in a book or the internet without awareness of its consequences. Limited social imagination and awareness of consequences facilitate the process of dehumanisation of the enemy, typically used by terrorists to legitimise the use of violence against the enemy;
Need for order, rules, routine and predictability	Extremist explanations may provide the orderly solution to the chaos of the world as they promise absolutist solutions.
Obsession, Repetition & Collecting	Once the individual with autism has accepted an extremist theory of the world, it can become an obsession. Attempts to discourage certain repetitive behaviours could trigger reactive aggression from individuals with ASD.
Social and communication difficulties	Often people with ASD feel isolated and lonely. The internet can act as a safe haven for autistic people for whom social interaction is difficult (degree of control). In addition, they may fail to discern between extremist propaganda and facts, rendering them a good target for exploitation by radical groups. Also, internet 'friends' who validate skills and promise 'justice' and 'moral certainty' can influence an individual very quickly ([13]). Furthermore, a research pointed out that in 35% of violent cases towards others, most of it was reportedly attributed to social misinterpretations of the victims' intentions by the person with ASD ([14]). As autism is a problem of social communication, instead of talking about ASD, we need to assess the level of a person's social cognition.
Social naivety	Their increased social naivety may leave people with ASD open to manipulation by others, which is often exploited by recruiters of extremist groups
Cognitive styles (Difficulties & Strengths)	Given their so-called cognitive "myopia" (i.e. they tend to focus on something and ignore the rest), extremist views may make sense to people with an ASD because they provide a clear and dual explanation of the world. The importance of visual processing may push them to write, draw or keep images relating to a group or ideology.

[12] Al-Attar, Z., Autism & terrorism links – Baseless headlines or clinical reality? XI Autism-Europe International Congress, Autism-Europe & National Autistic Society, Edinburgh, September 16–18 2016.
[13] Idem.
[14] Bjorkly, S., Risk and dynamics of violence in Asperger's syndrome: A systematic review of the literature. Aggression and Violent Behavior, Vol. 14, Iss. 5, 2009, 306–312.

Processing - Sensory Hyper & Hypo-Sensitivity	They may seek vivid extremist images and may find weapons to be aesthetically appealing (i.e. they produce bright lights and loud noises). Alternatively, sensory avoidance may lead to them being house-bound, meaning that the only means to socialise is through the virtual world, where they can stumble upon radical ideas easily. Many individuals with an ASD report sensory hypersensitivities as their main cause of stress ([15]) and, in some circumstances, offending has been linked to a specific sensory hypersensitivity ([16]).

Other insights to consider are:

- **Intellectual functioning and Intelligence Quotient (IQ).** Lower IQ has been found to be associated with aggression in children with ASD ([17]).
- **Gender.** Långström, Grann, Ruchkin, Sjöstedt and Fazel([18]) found that male gender and higher chronological age were associated with engagement in violent crimes.
- **Social-economic demographics**. Kanne and Mazurek ([19]) reported various demographic variables that were associated with violence in children with ASD; including lower chronological age and coming from a family with higher income.

Psychotic disorders, co-morbidity and delusional patients

When patients suffer from psychotic disorders, it is difficult to assess to what extent someone is radicalised or whether the actions are related to the **delusion**. **Psychotic illness** is linked to increased rates of violence in adolescents and adults both with and without autism and intellectual disability. A study on this topic concluded that most violent individuals with ASD suffer from comorbid psychiatric disorders that raise their risk of offending, as they do in the general population ([20]).

We can observe that recent violent attacks and mass murders committed by young men whose social isolation borders on autism also seem to have fallen prey to **psychotic ideation**. Autism itself is not an intrinsically violent disorder, and individuals with ASD are no more prone to violent behaviours than the general population. The additional presence of psychotic illness, however, may dramatically change the picture. **Radicalisation in these cases may serve as a frame, or a way of expressing psychotic disorder**. Some observations to consider are ([21]):

[15] See for example Robertson, A. E., & Simmons, D. R., The sensory experiences of adults with autism spectrum disorder: A qualitative analysis. Perception, Vol. 44, 2015, 569–586.
[16] See for example Mawson, D. C., Grounds, A., & Tantam, D., Violence and Asperger's syndrome: A case study. The British Journal of Psychiatry, Vol. 147, 1985, 566–569.
[17] Kanne S. M., & Mazurek, M. O., Aggression in children and adolescents with ASD: Prevalence and risk factors. Journal of Autism and Developmental Disorders, Vol. 41, Iss. 7, 2011, 926–937.
[18] Långström, N., Grann, M., Ruchkin, V., Sjöstedt, G., & Fazel, S., Risk factors for violent offending in autism spectrum disorder: A national study of hospitalized individuals. Journal of Interpersonal Violence, Vol. 24, Iss. 8, 2009, 1358–1370
[19] Kanne S. M., & Mazurek, M. O., Aggression in children and adolescents with ASD: Prevalence and risk factors. Journal of Autism and Developmental Disorders, Vol. 41, Iss. 7, 2011, 926–937.
[20] Newman, S. S., & Ghaziuddin, M., Violent crime in Asperger syndrome: The role of psychiatric comorbidity. Journal of Autism and Developmental Disorders, Vol. 38, Iss. 10, 2008, 1848–1852.
([21]) Wachtel, L. E., Edward Shorter autism plus psychosis: A 'one-two punch' risk for tragic violence? Medical Hypotheses, Vol. 81, 2013, 404–409.

- Individuals with ASD have an elevated risk of comorbid psychopathology, including psychosis, which is strongly associated with violence.
- The content of psychotic ideation has become increasingly violent and lethal in recent decades.
- It is possible that individuals with ASD are readier than others to act on psychotic impulses

The behaviour of individuals with a psychotic illness is **difficult to predict**. Recognising the increased susceptibility of individuals with autism or other neurodevelopmental disability to connected psychotic illness increases the possibility that they can be correctly identified and treated. **Autism needs to be considered alongside any other psychological, neurological or physical impairment**s and it is important to consider how the different factors interact to shape an individual's experience and behaviour. **Support may also need to be multi-dimensional** (e.g. therapy and medication for mental health difficulties and physical support for physical difficulties, alongside an autism-tailored rehabilitation approach). In this particular challenge, medication can be a good preventive measure to help them stay focused and prevent delusions. For the **treatment-resistant patient or schizophrenic patients, Assertive Community Treatment could be considered.**

Assertive Community Treatment (ACT). ACT is a multidisciplinary team approach to intensive case management in which team members share a caseload, have a high frequency of patient contact (typically at least once a week), low patient to staff ratios, and provide outreach to patients in the community. ACT teams include psychiatrists as well as other mental health clinicians. This team approach allows for integration of medication management, rehabilitation and social services. ACT treatment is typically ongoing rather than time-limited, available 24 hours a day, and highly individualised to each client's changing needs. The goals of ACT are to reduce hospitalisation rates and help clients adapt to life in the community. ACT is most appropriate for individuals who are at high risk for repeated hospitalisations and have difficulty remaining in traditional mental health treatment ([22]).

Risk assessment guidelines for ASD

Besides well-known risk assessment tools like VERA2 or ERG, there is a specific guideline for ASD complementary to risk assessment tools, named FARAS ([23]). This document provides clear guidelines and addresses autistic functions of risk and protective factors. Different aspects of autism may play different roles in shaping a pathway to terrorism. The guidelines aim to provide risk assessors an overview of considerations that are important to take into account when dealing with an offender with ASD.

The prediction of risk of violence is not an exact science. Therefore, the following ethical restrictions need to be considered:

1.	Limitations and strengths of assessments;
2.	The complexity & multitude of risk factors;

([22]) See: https://www.div12.org/treatment/assertive-community-treatment-act-for-schizophrenia/
([23]) The author of FARAS is Dr Zainab Al-Attar, who can be contacted via: Zainab.al-attar@hmps.gsi.gov.uk

3.	Potential protective factors;
4.	Means of reducing risk;
	If detention or forced admission is necessary:
5.	Identify evidence-based treatment options;
6.	Try to minimise distress and maximise quality of life.

Protective factors

A comprehensive P/CVE programme should not only aim to weaken and reduce risk factors but also to enhance protective and promotive factors. There are factors that may predispose an autistic individual to be radicalised. There are also factors in autism which would mitigate against involvement in any illegal activity.

The fact that someone is being treated is considered a **protective factor, demonstrating the importance of access to services and healthcare**. This access goes both ways; it is important for someone to have access to healthcare but likewise it's of added value for healthcare services to have access to someone with a risk of radicalising. We should focus on decreasing vulnerabilities (thus increasing resilience) and be quicker than the recruiters. Furthermore, the absence of a **history of violence** might be considered a protective factor.

Diagnosing

At the expert meeting, the question of whether or not a **diagnosis is needed** before planning your intervention was subject to debate. Some considered it necessary, while others did not. There was also the question whether or not the diagnosis is to be **shared with the patient**. There was some agreement that diagnosing or not depends on the case and the **specific context**. In some cases diagnosis might actually have a negative influence on the intervention and/or person concerned, so caution is advised. It most important to understand and recognise the traits of ASD to plan the intervention accordingly.

Interventions and treatment

Understanding the past of the person concerned was considered crucial. **Trauma awareness is crucial in planning the intervention**. Documenting what the individual considers life's injustices will assist in understanding **grievances**. Practitioners need to be aware of **how biography affects the current situation**.

Some differences in chosen approaches were discussed. **The medical approach** is to diagnose and treat, while trying to maintain safety and function. In addition, **the person-centred approach** of trying to understand and address psychological and emotional distress is required. There was agreement that both approaches need to be considered and are, again, **context specific**.

Two intervention examples, one specifically for someone with ASD and one for schizophrenia, demonstrated some overlap in how to plan an intervention. In their interventions both focused on three protective factors:

1) Skills

One of the easiest ways of engaging with the person is to find out what the person can do. What skills does he/she have? People with autism have an **ability to focus on detail** and may be able to concentrate for long periods on a single activity if it is of interest to them. They can give their sole attention to a task and,

therefore, can often achieve a high level of skill. Some examples include cooking, technological skills or gardening. When planning an intervention, it helps to focus on these skills and find a way to use them.

2) Mapping the social network

Before people with ASD have a group they belong to, they are often **lonely**. Recruiters give them attention and an orderly solution for the world (black and white). The faster someone **succeeds in building up a social network** outside the extremist group, the faster the person can leave. But how do you achieve that? People with ASD have difficulties with social interactions, so building up a new social network will be difficult for them. Some organisations with a wide network of people who have left extremist movements (formers) could be approached, but also sports clubs and the "old" social network – provided this doesn't include extremists. The old social network, including family, can be a protective factor. Also note that **communication for people with ASD is very rule-based** and they need guidance in developing their new social skills. **Another example included a community approach**. A (semi)closed community could provide a safe place for someone to build up a new social network and start with activities based on their skills so that they can once again get used to a non-extremist environment.

Psychoeducation. *Offered to patients and family members, it teaches problem-solving and communication skills and provides education and resources in an empathetic and supportive environment.* ***There is some risk to take into account here****: It should be considered how much the patient already understands and how much knowledge the patient can take up and process in their current condition. The ability to concentrate should be considered as well as the maximum level of emotional stress that the patient can take.*

3) Dealing with ideology

When it comes to people with autism, **dealing with ideology is a challenge**. People with autism want to have rules to live by; they want to be instructed on how to engage socially. **They tend to be fused with the ideology more than people without ASD**. This is exactly why it is easy for them to interact with extremist movements and why it is much more difficult for them to leave these groups. The extremist movements give them scripts on how to act within a group. Therefore, **if they do not have a script to live by, they are vulnerable to radicalisation and recruiters**. Some ideas on how to solve the issue were brought forward.

What can you do? Make them understand **that it is the ideology that's dictating how they feel**. They have been part of a system that instructed them on right and wrong. If they only have their **ideology to understand the world**, you can **give them another system** that is, in some way, less harmful to them. Another system will provide them with other rules to live by. One example discussed involved a **moderate imam** who could understand the person's ideology and give something positive in return. However, the imam needed to be trained to differentiate religious aspects from obsession and how to communicate with schizophrenic or autistic persons.

Relation-frame theory*: use defusing techniques. Take things out of the language; if you say 'lemon' out loud many times in a row, it loses its meaning. You have to do more than tell someone this doesn't work. They have to experience it themselves (otherwise they just have another rule to live by).*

Recommendations for policy and practice

Below are recommendations for policy and practice on dealing with people with ASD, with a risk of radicalising or who were already radicalised, that were discussed.

Practical recommendations
• Provide practitioners with specific training on ASD to pinpoint the needs of individuals • Always involve **mental health workers** in risk assessments and exit work. A **multidimensional assessment** needs to be considered. • Use a **comprehensive approach** which includes multidisciplinary and community treatment with a **case coordinator** throughout the process. • **Think long term.** Changing someone's behaviour is a long process. • Experiences with possibly radicalised patients who had neuropsychiatric disorders or demonstrated psychotic behaviours in Amsterdam showed how important it is to **stay in contact with the person**, especially if they are imprisoned. Be open, honest and non-judgemental about someone's thoughts. • We need to avoid **stigmatisation** of people with mental health disorders. Tread with care. Understand that a diagnosis is an aggravating factor for the justice system. The fact that a person is diagnosed with a mental health disorder might mean a **higher risk of imprisonment** in some countries. • **Forced admission** can have many negative aspects with regards the wellbeing of patients and might even push them further down the pathway to violent extremism. • **Medication** was mentioned as an important aspect of treatment, as well as being open and honest with the patient. • Practitioners also need to **establish clear boundaries** when working with these persons. Two rules to remember when working with violent mental health patients: **previous violence is the best indicator for future violence** and **protect your back.** Obsession is a defence mechanism to keep their life in order so understand that you might be the target of their obsession. • **Look at a person's needs** rather than risks. Decreasing their vulnerability to radicalisation will increase their resilience. • **Try to establish whether presumed radicalisation is a consequence of a mental disorder or truly ideological**; they can be linked but not always. It is, therefore, important to define the specific aspects of the mental health disorders that pose a risk and might lead to radicalisation and to treat these accordingly. Practitioners need specific knowledge of ASD and its symptoms. • In the end, **it's business as usual**; use the skills you normally use and don't be afraid of the word 'radicalisation'. The clinician is the voice of reason.

Policy recommendations
• **Develop a P/CVE strategy** which includes mental health disorders and other mental health issues or incorporate these in existing strategy. • **Do a mapping exercise.** See what different countries are doing to obtain a benchmark. • **Triage system.** Develop a **frontline team of experts involved in psychiatry** to be included in the local multi-agency structure to determine whether a person is radicalised or should be in a radicalisation programme. Potential questions include whether psychotic patients have been radicalised. • **Fund research** to come up with more evidence-based interventions. • A **cost-effect analysis** is needed. This needs to take a long term approach. • Start a **hotline for radicalisation** which mental health workers can call when they suspect their patient is radicalised.

Conclusion

Mental health disorders can be a **pathway** leading to violent extremism as **symptoms** may include a tendency to violence or social structures could lead to a violent expression of symptoms. Mental health should be considered in both its **direct and indirect effects** in promoting radicalisation. **Recognising traits** of a mental health disorder are crucial to planning any intervention. By looking at radicalised people with ASD, we learned that **certain characteristics can make people with ASD more vulnerable to radicalisation** and violent extremism. Often, they are influenced by recruiters of extremist groups. Traits of ASD can be **both a risk and a protective factor**. Considering which traits are more prominent in the individual will assist the professional in making a **tailor-made assessment**. Clinicians should **focus on the needs** of the person concerned and build their **intervention** around that. Treating people suffering from psychotic disorders might require a **medicinal approach** and it should be taken into account that **radicalisation can also be an expression of psychosis or delusion**. They can be linked but this is not necessarily the case. The most important protective factor is **access to healthcare services**. More research on other different mental health disorders and pathways is needed to establish the linkage with radicalisation.

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